

BROOKLYN DEVELOPMENTAL CENTER

ADAPTIVE EQUIPMENT SHOP WORK REQUEST

Program/RESIDENT VALARIE Young WING 314 DAY PROGRAM _____Requested by O.T. Date 2-3-05EQUIPMENT to be repaired or modified: _____
(ie. wheelchair, chair, etc.)SERIAL NUMBER _____
What needs to be done or problem description.

Located, repaired and installed w/ lateral elevating legs.

Approved _____ Date _____
Physician

Continue on other side or attach additional sheet, if necessary.

DATE Referral received: 2-3-05 DATE Assigned: 2-3-05
AES Assigned: [Signature] DATE Completed: 2-3-05
SIGNATURE OF PERSON RECEIVING EQUIPMENT: [Signature] DATE 2-8-05

Total work time in hours: 1 HR

Material used:		Qty		Qty
() H.D. polyethylene	_____		() Leg rests	_____
() Kydex	_____		() Wheels	_____
() Foam	_____		() Armrests	_____
() Naugahyde	_____			
() Nuts	_____ Bolts			
() Webbing	_____			
() Other:	_____			

2-3 P = 1 HR